

Health Home Learning Collaborative

Person Center Service Plan For
ICM

11/4/2020

This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

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AGENDA

Introductions

Person-Centered Planning Philosophy & Documentation.....Tori Reicherts, ITC

Open Discussion.....All

Learning Objectives

Participants will learn

- Definition of person-centered planning
- Why person-centered planning is important
- Philosophy of person-centered planning
- Documentation - how to complete the Person-Centered Service Plan (PCSP)

Person-Centered Planning Definition

- Person-Centered planning is a holistic, recovery oriented process, directed by the member, building on the member's strengths, capacities, preferences, needs and desired outcomes of the member.
- For minors, when referencing "member" it's understood that parents/guardians are the decision-makers for the actual member receiving the services. Before making decisions, the voice of the "member" is taken into consideration.
- For court-appointed guardians of adults, the specific decision making responsibilities of the guardian as outlined by the courts **MUST** be documented in the plan.

Person-Centered Planning Why

- Gives respect to members
- Engages members in their own health care
- Improves care
- Utilizes strength-based philosophy
- It's the right thing to do

Person-Center Planning Philosophy

Person-centered service planning requires:

- Time needed to learn what is important to the member and to support the member in having control over the process and content
- Strengths-based development, language, and writing
- Commitment to the member
- An individual-driven process that includes people who the member wants involved in the planning process
- A plan that the member cares about and includes the goals of the member in his or her own words

First Person Language

- First, second, and third person are ways of describing points of view
 - **Define first person:** The definition of first person is the grammatical category of forms that designate a speaker referring to himself or herself. First person pronouns are I, we, me, us, etc...
 - **Define second person:** The definition of second person is the grammatical category of forms that designates the person being addressed. Second person pronouns are you, your, and yours
 - **Define third person:** The definition of third person is the grammatical category of forms designating someone other than the speaker. The pronouns used are he, she, it, they, them, etc...
- **First Person Example:**
 - I prefer coffee to hot cocoa

First Person Language Cont'd

- **Second Person Example:**
 - You prefer coffee to hot cocoa
- **Third Person Example:**
 - He prefers coffee to hot cocoa
- **Trick to Remember the Difference**
 - In the first person writing, I am talking about myself
 - I enjoy singing.
 - In the second person writing, I am talking to someone
 - You enjoy singing.
 - In the third person writing, I am talking about someone
 - He enjoys singing



Outcomes

Quality person-centered service plans ensure that planning leads to important outcomes

- People have control over the lives they have chosen for themselves
- People are recognized and valued for their contributions (past, current, and potential) to their communities
- People live the lives they want

DOCUMENTATION



Important Items

- Fill out PCSP completely
- Do not leave fields blank unless instructed to do so
- Free text goes in the gray boxes
- Check for spelling and grammar errors
- The use of N/A is not allowed in the PCSP, instead state “ I do not have that particular item”, referring to the correct section of the PCSP or “I have no needs at this time”
 - This will ensure you have asked the question

PCSP Expectations

- Completed timely
 - Initials – completed within 30 days of the approval of LOC
 - Prior to the previous PCSP expiring
- Plans must not be longer than 365 days
 - For ITC –plans should end the last day of the month that the LOC expires.
 - For AGP – plan dates will align with the Level of Care dates

PCSP Expectations

- Review interRAI, Comprehensive Assessment & Social History to
 - Build your PCSP by identifying any
 - Risks that member may have &
 - Needs the member has identified
 - Risk and Need must be captured throughout the PCSP
 - » Risks/Needs Section
 - » Goals
 - » My Self-Management Plan (safety/crisis plan)
 - » Service Section
- Assessments always drive your PCSP

Section 1

PCSP Information

PCSP Information

- Header
 - Double click and fill out
 - Members Name, DOB, SID
- Type of Person Centered Service Plan (PCSP)
 - Initial: New to CMH waiver or Habilitation
 - completed within 30 days of the LOC
 - Annual: Completed within 30 days of the annual Level Of Care Assessment
 - Revised: Completed any time a change to the existing Person Centered Service Plan takes place
- Program Type:
 - Habilitation or Children's Mental Health
- Date Person Centered Service Plan held:
 - This is the date of your Interdisciplinary team meeting and the date you capture the attendance signatures



PCSP Information Cont'd.

- Person Centered Service Plan (PCSP) Date Span:
 - Initial: PCSP usually have a date span of 1 year (9.1.19 - 8.31.20) and typically start on the first day of a month and end on the last day of the month; but sometimes they may start right away for new members (9.23.19 – 8.31.20)
 - Annual: PCSP typically has a date span of 1 year (9.1.19 - 8.31.20)
 - Revised: PCSP will keep the same date span as the existing PCSP. Show the start date of the new services in the service authorization grid in the proper section of the PCSP
- Previous PCSP Date Range:
 - Leave blank if this is initial
- InterRAI Date:
 - Most recent date of the InterRAI Assessment

PCSP Information Cont'd.

- Integrated Health Home: **Health Home Name**
- Care Coordinator Name: **Name of the Care Coordinator**
- CC Phone Number: **Phone Number**
- CC Email: **Email**
- Managed Care Organization: **Choose from drop down**
- Comprehensive Assessment Date: **Enter the date the Comprehensive Assessment was completed**
- I choose the following location for my PCSP meeting
- I choose the following date and time for my PCSP meeting
- I choose the following people to attend my meeting

PCSP Information Cont'd.

- I choose _____ to lead my meeting:
 - This is a very important question that you must ask the member, do not assume
 - Who does the member wants to lead the Interdisciplinary Team meeting? (may be themselves, their guardian, a natural support, a provider, or you the care coordinator)
 - You must ask
- Revisions, Only:
 - Date of Revision: This is the date of the meeting for the revision
 - Reason for my revision: Check the appropriate response and add the reason
 - The following sections in my PCSP were revised: Check all that apply to the revision

Section 2

My Information

My Information

- My address: Member's current address where they live, including city, state, and zip code
- Name of facility (if applicable): if member is residing in the facility, note the name
- Phone: Members current phone number, including area code
- Email Address: Members current email address
- I have advanced directives in place: Mark yes or no
- My strengths are: What are you good at? What do your friends like about you? Ask the team for input.
 - Example: "I am great at cooking", "I am a nice friend", "I have a good memory".
- My preferences are: Are you a morning or afternoon person? What type of staff/providers do you like to work with? "do you like reminders?" "do you prefer male/female staff?"
 - Answers you may receive include:", "I like it when I get a reminder call about my meeting the day before", "I would like to have female staff help with my bathing and dressing". Preferences may be based on cultural or religious beliefs

My Information Cont'd.

- How you can support me: “How can team support you when you are having a bad day? How can team support you when you are doing well? “
 - List supports provided like reminders to take medications, listen to me when I am upset, take my medications or PRNs, get my groceries, provide reminders to shower by 10 AM.
- My cultural preferences are: identify any cultural preference member has that influences how health and healthcare is perceived and received
 - Such as languages, festivals, rituals, ceremonies, holidays
- My cultural accommodations are: identify values and beliefs and how providers accommodate them in public while maintaining the parent culture in private.
- My communication preferences are: identify the primary language member speaks and read, non verbal, etc.
- My communication accommodations: identify things to assist in communication – i.e. language interrupter, communication device – be specific, provide written word in different languages, braille, etc.

My Information Cont'd.

- My physical health diagnoses include: list all current medical diagnoses/conditions the member has
- My mental health diagnoses include: list all current mental and behavioral health diagnoses
- My Care Team Members: list all people who support the member
 - Include people/agencies such as:
 - Guardian, Power of Attorney, service providers, school, payee, MH Advocates, Court Involvement (foster care, CINA, etc.) natural supports, IHH Team, etc...
 - Fill it out each section completely including name, agency/title, address and phone numbers
 - If person was at the meeting check the box present at the meeting

Section 3

My Risk Factors & Needs

My Risk Factors & Needs

- These are the Risk Factors that are identified from the interRAI Level of Care Assessment, Comprehensive Assessment, Social History, and other records
- First Person language may be a challenge in this section
- List the risk factors/background information and plans to minimize, including back up plans and strategies to address the risk and/or need

Notes for this Section:

- Do not leave any blank or N/A the fields
- If the member has none simply state th



My Risk Factors & Needs Cont'd.

- **What is a risk factor?**
 - A Risk Factor is something that increases a member's risk or susceptibility
Risk factors may be associated with a member's
 - mental health status, health & wellness, medications, environment or be behavioral related
- **Types of risk factors**
 - Health Risk Factors
 - Personal Safety Risk Factors
 - Behavioral Risk Factors

My Risk Factors & Needs Cont'd.

- By identifying a member's Risk Factors, the member and their interdisciplinary team can work towards managing them
- Managing Risks = Better Outcomes
- Also Remember:
 - All people take risks
 - However, people with disabilities and elderly may be more vulnerable from effects of the outcomes
 - Identifying risks does not take away a member's right to make decisions
 - In fact, the member may choose to participate in behaviors/actions that increase, instead of mitigate the risk

Areas of Risk Factors & Needs

- Consist of 3 main areas
 - Category of Risk/Need from Assessment
 - Identified Risk Factor/Need with Background Information
 - Measures to minimize, including back-up plans & strategies when needed

Types of Risks Factors/Needs

- Allergies
- Behavior
- Cognition & Executive Functioning
- Communication & Language
- Cultural
- Developmental Milestones (children only)
- Domestic Violence, Physical, Emotional, Sexual Abuse
- Educational
- Employment/Volunteering
- Environmental
- Financial/Money Management
- Gambling/Dependence
- Harm to Self & Others
- Hearing
- Hospitalization/ER Visits
- Housing
- I-ADLS & ADLs

Types of Risks Factors/Needs

- Legal
- Leisure Activities
- Medications
- Medical Support Team
- Mental Health
- Nutritional Status
- Physical Health Conditions
- Preventative Visits
- Service Utilization & Treatment
- Social & Family Relationships
- Spiritual
- Stress & Trauma
- Substance Use or Excessive Behaviors
- Transportation
- Vision
- Other

Risks Factors/Needs Examples

<u>interRAI</u> assessment sections	Identified risk factors/Background Information	Measures in place to minimize, including back-up plans and strategies when needed
Mental Health	I am diagnosed with Bipolar disorder and there are times I become manic and where I do not sleep for 2 or more days in a row and struggle to follow conversations.	I take my medications daily. I need my team to identify when I am showing signs of mania and check to ensure that I am taking my medications correctly, may need to go my dad's to change my routine. I may need my team to reach out to my psychiatrist to see if I need a medication change.
Substance Use or Excessive Behaviors	I have none identified	None
Physical Health Conditions	I have been diagnosed with Huntington's Disease. As this disease progress my motor skills slowly decline. At this time, I have fallen 3 times in the past month.	I currently use a cane or walker to get around to assist me with my balance. I prefer to have staff/family walk beside me when there is snow out to assist me so I don't slip and fall, if they are not able to pull the car up to the door. I also have a fall alert system that I use when on my own.

Risks Factors/Needs Examples

Educational	I currently have an IEP at school due to my ADHD as I struggle to stay on task, display aggressive behaviors such as throwing items when I become upset, and struggle with communicating with my peers and teachers.	My IEP states that I need to have a 1:1 aide at school to assist me throughout the day. My parents feel this is what I need to be able to learn effectively at school and to assist me with communicating with my peers by saying hi, offering to shake their hand instead of hugging them or throwing things at them.
Employment/Volunteering	I currently am accessing employment services through school as I need assistance with finding a community job as I would like to work at Pizza Hut doing dishes.	My IEP has me set up with vocational services where I get to try different jobs to see what I like. I need a job where I can work more on my own at my own pace as I become overwhelmed when I have to do too many things at once. My team may look at IVRS for funding.

Section 4

My Goals

My Goals

- SMART
 - **S**pecific.
 - **M**easurable.
 - **A**ttainable.
 - **R**elevant.
 - **T**ime Bound/Timely/Time Based
- Member Language
- Goals should be incremental unless you have a maintenance goal
- All waiver and habilitation services should have at least 1 goal
- Goals in IHH plan are a guide for the providers plan.



Parts of the Goal

- I want
- My expected objective
 - I will
- Background/barrier(s) to meeting goal
- If I had to rank this goal on how important it is to me or my or my caregivers

Parts of the Goal

Intervention and supports, including incremental action steps

- Incremental action steps should reflect the goal and describe what the goal looks like
- The best way to find out what the incremental action steps should be is to have a discussion with the team during the meeting
- The background will also assist you with incremental action steps so filling this out first can help you

Interventions and supports, including incremental action steps	Person Responsible	Start Date	End Date

Parts of the Goal

- Who is Responsible
 - Who will be assisting with teaching/maintaining that step
- Start Date
 - Will be the begin date for that incremental step
- End Date
 - When will the member have learned or met that incremental step

Goal Examples

Skill-Building Goal Example – I will exercise 3 times per week for 30 minutes by 7/31/2020.

I will exercise 1 time per week for 20 minutes	Clifford & Loving Care SCL	8/1/2019	10/31/2019
I will exercise 2 times per week for 20 minutes	Clifford & Loving Care SCL	11/1/2019	1/31/2020
I will exercise 3 times per week for 20 minutes	Clifford & Loving Care SCL	2/1/2020	4/30/2019
I will exercise 3 times per week for 30 minutes	Clifford & Loving Care SCL	5/1/2020	7/31/2020

- **Maintenance Goal** – I will receive respite at least once a quarter through 7/31/2020.

I will schedule my respite times.	Parents & XYZ Respite	8/1/2019	7/31/2020
I will identify what I would like to do during respite hours.	Parents, Clifford, XYZ Respite	8/1/2019	7/31/2020
I will follow my safety/crisis plan as needed	Clifford & XYZ Respite	8/1/2019	7/31/2020
I will attend respite as scheduled.	Parents, Clifford, XYZ Respite	8/1/2019	7/31/2020

Section 5

My Services & Supports

My Services and Supports

- **Includes**
 - Waiver or Habilitation Services (Medicaid Funded Services)
 - Reductions & Terminations for Waiver or Habilitation Services
 - Non Waiver/Habilitation Services and Supports
 - Services or Supports that are needed but declined, not available, or accessible
 - Natural Supports
 - Resources (unpaid services)
 - Backup Plan for Services
 - Discharge Plan for Services

My Waiver or Habilitation Services (Medicaid Funded Services)

<ul style="list-style-type: none"> My Waiver or Habilitation Services (Medicaid Funded Services) Provider Responsible	Name of Service	Service Code & Modifier	Units	Frequency	Rate (CMH Waiver)	Start Date	End Date
				Month or Year			
				Choose an item.			
				Choose an item.			

My Waiver or Habilitation Services

- Provider Responsible & NPI Number –
 - Enter in the name of the provider for the service you are requesting, along with the NPI number
 - Spell out the provider name, do not use acronyms.
 - You should always list the IHH for Case Management Services, 99490 U1/U2
- Name of Service -
 - Where you will identify the name of the service such as case management, Home Based Hab (HBH), Supportive Employment, Respite, In Home Therapy, etc.
- Service Code & Modifier –
 - Identify the Code # for the service, if the service has a modifier also identify that such as H2016 UA, H2023 U5, T2020, S5150 UC, T2036, H0046, etc.

Habilitation – Name of Service, Service Code & Modifier

Name of Service	Service Code	Modifier(s)
IHH PMPM	99490	U1 or U2
Day Habilitation (DH) Full Day	T2020	No Modifier
Day Habilitation (DH) 15 minutes	T2021	No Modifier
Home Based Hab (HBH)	H2016	UA, UB, UC, UD, U8, U9
Supportive Employment (SE) Small Group	H2023	U3, U5, U7
SE Long Term Job Coaching (LTJC)	H2025	U4, U3, U5, U7, UC
SE Prevocational Services, per hour	T2015	No Modifier
SE Career Exploration	T2015	U3
SE Individual Hourly	T2018	UC

CMH Waiver – Name of Service, Service Code & Modifier

Name of Service	Service Code	Modifier(s)
IHH PMPM	99490	U2
Respite – Individual	S5150	No Modifier, UC
Respite – Specialized	S5150	U3
Respite – Group	T1005	No Modifier
Respite – Group (hospital or NF RCF)	T1006	U3
Respite – Resident Camp	T2036	No Modifier
Respite – Day Camp Group	T2037	No Modifier
In Home Therapy	H0046	No Modifier
Family & Community Support	H2021	No Modifier
Environmental Modification & Adaptive Devices – Home Modification	S5165	No Modifier
Environmental Modification & Adaptive Devices – Personal Care	S5199	No Modifier
Environmental Modification & Adaptive Devices – Specialized Supply	T2028	No Modifier

My Waiver or Habilitation Services

- Units –
 - Enter in the # of units requested for that service
 - Make sure to verify usage from previous 3 months to year
- Frequency –
 - Select Month or Year depending on how frequently you are needing number of units for the service
- Rate –
 - This is only for CMH waiver services.
- Start Date –
 - The date the service is to begin (for initial requests) or
 - The date the service is to be renewed.
 - This date must fall within the PCSP date range list on page 1
- End Date –
 - Must fall within the PCSP date range list on page 1, but no later than the last day of the PCSP plan end date

Reductions or Terminations To My Services

- Must document all reductions and terminations in the PCSP
 - Even if these services end at the annual PCSP and/or member choice
- Allows
 - Tracking for reporting to DHS and
 - Notice of Appeal Rights to be mailed to member
- Captures
 - Effective Date of the change – have to allow at least 14 days for appeal rights
 - Service and Modifier that is being affected
 - Original Units member was receiving
 - New Units the member will be receiving
 - Reason for the termination and
 - How members needs will be met after the change
- For ITC, per DHS the reason/rationale on all three documents must match –
 - MRA, PCSP, and the NOA

Reductions or Terminations

- Effective Date – is the date the termination or reduction will be in effect
 - We must allow for 14 days appeal window for the member.
 - The date on the PCSP must align with the NOD date
 - For ITC – also must match the effective date in the Member Reporting Assessment (MRA). The dates will always ends the last day of a month, depending on when the PCSP is uploaded to ITC and MRA is completed. See MRA Guidebook for more direction.
- Service Code & Modifier – identify the service code and modifier, if one is applicable for that code, that is changing
- Type – chose from drop down between
 - Reduction
 - Is reducing the number of units within the same service & modifier
 - Termination –
 - is ending a service completely or
 - when changing modifier within the same service code, i.e. H2016 UD to H2016 UB, exception is small group supportive employment.

Reductions or Terminations

- Original Units - the # of units requested in the original PCSP
- New Units – New # of units member is going to access of the service
 - Terminations will always be 0
- Reason – Choose from the drop down
 - Duplication of Service
 - Facility Placement
 - IDT Decision for medical or behavioral changes
 - In excess of standards identified in Iowa Code
 - Member Choice
 - Individual no longer eligible
 - Needs being met by other source or other service
 - Previous units exceed needs
- My Need is now being met by - identify services and supports the member is going to be receiving to keep member safe and can include natural supports

Example of Reductions or Terminations

Reductions or Terminations to My Services

Effective Date	Service Code & Modifier	Type	Original Units	New Units	Reason	My need is now being met by
9/30/20	H2016 UB	Reduction	20	10	Member choice	Receiving HBH, prevoc & natural supports
9/30/20	S5150 UC	Termination	280	0	Need being met by other source or other service	Accessing respite day camp group (T2037) & natural supports

My Non Waiver/Habilitation Services & Supports

- List all Medicare, straight Medicaid, private insurance, regionally-funded, education supports/services or otherwise non-waiver services here. This may include PCP, medical and/mental health professionals, Non Emergency Medical Transportation (NEMT), incontinence supplies, etc.

Service Name	Funding Source	Agency/Person Responsible	Phone Number	Frequency of Service	Start Date (month/yr)
Medications	Medicare	ABC Pharmacy	111-111-1111	Monthly	8/2018
PCP, Cardiologist	VA	VA – IA City	111-000-0000	As needed	7/2015
1:1 Aide	Keystone AEA	XYZ Community School	000-000-0000	5 days week	9/2020
RCF	Region	County Social Services	222-222-2222	Daily	8/2016
Transportation	Medicaid	Access To Care – ITC	333-333-3333	As needed	9/2020

My Non Waiver/Habilitation Services & Supports

- In this section you will identify the following
 - Service Name – such as Court Ordered Services, PCP, Psychiatrist, Dentist, Eye, Counselor, Physical therapy, ACT, Schools, AEA, etc.
 - Funding Source – such as Medicare, Medicaid, Private Insurance, Region, etc.
 - Agency/Person Responsible – identify the provider name or agency name
 - Phone Number – include area code
 - Frequency of Service – how often the member sees the provider i.e. weekly, monthly, yearly, as needed, etc.
 - Start Date – in Month & Year format
- If I receive speech, physical, or occupational therapy along with day habilitation, my services are being coordinated in this way – document how and when the member is receiving these services to ensure that there is no duplication of service

Services or Supports that are needed but declined, not available or inaccessible

- If applicable, identify the following
 - Service – identify the service not being utilized
 - Reason the member is not utilizing the service – choose from the drop down
 - Declined – member does not want the service offered
 - Not available – member would like to have a service but it is not available to them, such as no provider in the area
 - Inaccessible – member is on a waitlist with the provider
 - How the need is being met – identify what is being done to ensure the member's health and safety
- If none, make sure to make a note that none identified.

Example - Services or Supports that are needed but declined, not available or inaccessible

Services or Supports that are needed but declined, not available, or inaccessible

Service	Reason for not utilizing	How is the need being met?
Fam. & Community Support - H2021	Not Available	Family is accessing family therapy at XYZ provider.

My Natural Supports Are

- Natural Supports are unpaid supports the member is able to access for support to live independently and safely in the community.
- In this section you will,
 - Identify the Name of the person or agency
 - Relation to the member – parents, spouse, Legal Decision maker, Financial Decision Maker/Payee, siblings, other family members, friends, neighbors, church members, support groups, bank, etc.
 - Training or resources needed to provide support – identify if the natural support needs any additional training or support to assist the member
 - If support needs additional training, answer the My support will receive training or resources question
 - How does this person provide support – document how they support the member such as, transportation to/from work, school, banking, socialization, etc.
 - My supports will receive the following training or resources (how, when, where) – identify what training will be provided to the support, include how, when & where

Resources that I use (unpaid services)

- Identify services that the member uses to remain safe, healthy and maintains independence to reside in the community, such as food pantry, support groups, church, etc.
- Identify the Resource or contact name
- Description – identify what supports are provided

Resources that I use (unpaid services)

	Resource / Contact name		Description

My Backup Plan for Services

- For each CMH waiver and habilitation service, you must identify a detailed backup plan incase the provider of that service is not able to provide the service.
- Think of what would the member do if service was not provided for:
 - Due to a natural disaster
 - Inclement Weather
 - Provider does not show
 - Provider becomes ill
- Back up Phone number – include on-call phone numbers for the provider or other numbers then member should try.

My Discharge Plan for Services

- A discharge plan should be documented for each CMH waiver or habilitation service the member receives.
- The disclaimer in this section should be reviewed with the member at each PCSP meeting.
 - I understand that waiver and habilitation services are voluntary and can be ended at any time. If I end my waiver or habilitation services, there may be an impact on my Medicaid, as well as, the service and supports for which I qualify. If I lose Medicaid eligibility, I will also lose my waiver and habilitation services. If my level of care changes or I reach all of my goals, I may not qualify for waiver or habilitation eligibility services anymore. If I do not meet with my Health Home Team, my waiver or habilitation eligibility could be impacted. In order to stay eligible for CMH waiver services, I must use at least one unit of service every three months.
- Must identify the following
 - Service Name – the name of the Waiver or Hab service such as IHH Case Management (99490), HBH, SE, Respite, In home therapy, etc.
 - Discharge Plan – must explain what needs to occur for the member to discharge from that service and specific to the member and their goals.

Section 6

My Self-Management Plan

My Crisis and Safety Plan

- Must be completed thoroughly on each member based on their abilities to get themselves to safety or who will assist them to safety
- If we have learned anything during the COVID 19 Pandemic and Derecho, it is the importance of having a thorough crisis and safety plan that can be activated at a moment's notice
- Anyone who reads your PCSP should have no question or doubt that the member can take care of themselves or know who will assist them
- This section should specifically identify exactly what the member will do under these circumstances or who is helping the member under these circumstances
 - State how the member will get from point A to point B
 - State what type of assistance the member will need to get from point A to point
- Should address the different settings the member is in such as home, work, school, etc.

Crisis & Safety Plan

- The crisis and safety plan will consist of the following items
 - Severe weather/tornado
 - Fire
 - Flood
 - Sick or Injured
 - Caregiver is sick or injured
 - Loss of electricity
 - Loss of water
 - Need to evacuate my home
 - What to do with children/pets if unable to care for them
- Make sure to be detailed and specific within each category and identify what the member can do, what supports they may need to remain safe in each category. Identify any medical conditions that may be at risk if any of these items last for more than 2 or 3 days.

Crisis & Safety Plan Example

In case of severe weather or tornado, I will seek shelter in the bathroom but I will need prompts from staff so that I get there quickly and take cover. I know that I need to stay inside to stay safe, but might need reminded. I will probably get nervous and need talked to in a calm voice. If I am at work or in the community, I will need staff direction on what to do and where to go to seek shelter.

In case of fire, I will exit the location via the nearest exits. I will need verbal prompts to do so quickly. I might need reminders not to take anything with me and just get out quickly. I am able to physically get out on my own. I will go out in the driveway/parking lot and wait for staff to tell me where to wait from there. If I am at work, I will need the same assistance. I am able to call 911 but I struggle with being able to provide my address. My home does have smoke detectors and fire extinguishers. Staff assists with checking and changing the batteries. Staff would use the fire extinguisher if needed.

My Medical & Behavioral Plan

- When I experience the following medical symptoms, these are the steps I take to manage them
 - List Medical Symptom – such as high blood sugar, stroke, falls, etc.
 - List What I do to manage on my own - identify what the member does to help manage those symptoms
 - List How others can support me - what things can staff and/or supports do when the medical symptom arises.

Medical Symptom	What I do to manage on my own	How others can support me

My Medical & Behavioral Plan

- Behavioral plan must be completed for all members -
 - If we do not ask, how would we know if the member is having an off day?
 - If the member has none it is better to state none than not to ask
 - By developing a behavior plan with the member when they are doing well, we are able to understand what they need and want to be supported when they are not doing well.
- Member who have known behavioral issues/concerns -
 - Elaborate the issues and/or concerns
 - Ask if habilitation or waiver providers have a detailed behavior plan that you can include with your PCSP

Behavioral Plan

- My baseline mood is:
 - Answer for every member
 - How do you describe your typical mood?
 - Are you easy going, Do you worry a lot?
 - Do you like to socialize with others or prefer to be by yourself?
 - Are you shy or quiet, Are your outgoing?
 - Are you usually cheerful or sad?
 - These will help you and others determine if something seems “off” with the member
- My triggers are:
 - What annoys them? What are their pet peeves?
 - What causes them to be sad, anxious or upset?
 - Examples: people joking with, thunderstorms, loud noises, crowded rooms, roommates taking stuff

Behavioral Plan Cont'd

- My early intervention plan is:
 - What helps the member when the above indicators are shown?
 - When does staff need to intervene?
 - Paint the picture so everyone knows what to expect
- The indicators that I need help are:
 - What does it look like when you are upset/sad/anxious/etc...?
 - Examples: I start pacing. I slam doors. I runaway. I get quiet and shut down. I isolate myself and don't return phone calls. I start calling everyone I know numerous times and don't stop until someone answers
- Members who do not have any “triggers”, “indicators” or an early intervention plan, you can state “I don't have any known indicators”.

Behavioral Plan Cont'd

- Things I can do to help myself are:
 - Some may be the same as above in the intervention plan
 - Examples: I will listen to music. I will go for a walk. I will meditate. I will practice coping skills
- My coping skills and natural supports are:
 - What are the members coping skills? Who is a good support for member when not feeling well?
 - Some may be the same as above in the things I can do to help myself section
- I have these supports available in the event I need to enact my crisis or safety plan:
 - List Provider Name by Specialty or add it to the blank area or insert rows if you need more
 - Make sure you include complete address and phone number with area code
- Review with member the IHH after hours phone number
- Review with the team the process for major incidents.

Section 7

My Right Restrictions

My Right Restrictions

What are Rights?

- Rights are the legal, social, or ethical principles of freedom or entitlement
- Rights are the fundamental normative rules about what is allowed of people or owed to people, according to some legal system, social convention, or ethical theory
- **Consider** the rights and responsibilities we experience every day (e.g., having consideration for people with whom we live, having a job and going to work, fulfilling a work or volunteer commitment, respecting coworkers, making choices within our income/budget) as we support people to navigate community life and consider benefits and consequences of their actions
- Our expectations for the members we serve should be the same as for any person living in the community
- All people have the responsibility to consider the thoughts and needs of others while exercising their own rights, priorities and preferences
- However, we also must consider the limitations people have that may restrict their choices (e.g., fiscal restrictions, physical restrictions, etc.)

My Right Restrictions Cont'd.

Rights that Apply to all Settings

- **Employment** - Members have opportunities to explore, seek and experience employment, including work in a competitive integrated setting if desired
- **Community life** - Members will have full access to the greater community including providing opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community to the same degree of access as people who do not receive waiver services
 - Members have opportunities and supports they need to be fully included in their community, individually and in groups, as desired
 - Rural communities may have fewer opportunities for people to participate in community events or gatherings, but this is also true for the general public
 - The key is to be sure people have the same access to the community as others who live in that rural setting

My Right Restrictions Cont'd.

Rights that Apply to all Settings

- **Medication** – Members able to manage and/or self-administer their medications. Do they know how to take them, why they take them, are they court ordered to take them to be medication compliant
- **Control of money** - Members have control over their personal funds and access to information about their income
 - Members have a way to access their money when they choose, not just during a set timeframe or business office hours
- **Privacy** - Members have the right to privacy, including: the right to have their information kept private and the right to have personal care provided in private
- **Dignity and respect** - Members shall be treated with respect and dignity in all aspects of life. Respecting a member for who they are is a basic human dignity
 - This includes respecting member's likes and dislikes, talking with members in a way that makes them feel respected and heard and assisting members with personal cares in a compassionate manner that preserves their dignity.

My Right Restrictions Cont'd.

Rights that Apply to all Settings

- **No coercion/restraint** - Members have the right to live in an environment free from coercion or restraint
 - The member is informed of their rights and is provided with instructions on how to file a complaint or grievance if their rights are violated
 - Member's are not bribed or coerced in to compliance
- **Independent choices** - Members have initiative, autonomy and independence in making life choices
 - This includes but not limited to daily activities, physical environment and with whom a member interacts

My Right Restrictions Cont'd.

- **Setting choice** - This requirement ensures member is aware of and has an opportunity to select where they would like to receive their waiver/habilitation services from and that their care coordinator documents their choices as part of their Person Centered Service Plan
 - Members can make an informed choice of where they live, work and receive services based on needs, preferences, financial resources and availability of settings, services and service providers
 - The Care Coordinator should give priority to the person's preferences, not the provider or guardian's preferences (unless for health and safety reasons)
- **Choice of services and supports** - Members have opportunities to choose whether they want to receive services, and they can choose from available alternatives when appropriate

My Right Restrictions Cont'd.

What are Right Restrictions

- An artificial or temporary limitation imposed on a person's freedom to engage or not engage in activities of daily living or choice
- Limitation on a person's privacy
- Rights Restrictions limit a member's autonomy and independence in making life choices, including but not limited to, privacy, daily activities, physical environment, and with whom to interact
 - Rights Restrictions should never be taken lightly
 - Restricting someone's choices and freedoms should only happen when the member's health and safety, or the health and safety of others is at risk

Examples of Right Restrictions

- Supervision at home
- Supervision in the community
- Required to check in with staff while in the community
- Representative Payee
- Legal Guardian – IAC Ch. 633
- Not able to make long distance phone calls
- Staff open member's mail
- Areas of the member's home that may be locked and inaccessible: medications, sharps, money, cupboards, closets, offices
- Staff having access to member's personal passwords or PINs
- Physician ordered diets and imposed dietary limits/restrictions to foods
- Member not allowed to smoke or limited smoking
- Member not allowed to consume alcohol
- Member not being able to lock their bedroom doors if they wish
- Member has medications administered to them
- Supervision while bathing, dressing, toileting
- No cooking without supervision
- Door alarms, video monitoring, baby monitors
- Probation

My Right Restrictions Cont'd.

Why implement right restrictions?

- To ensure the member's safety
- To ensure the member's health
- To ensure the safety of others (that would otherwise be in jeopardy if the member's rights were not restricted)
- **Rights Restrictions Must:**
 - Identify a specific and individualized assessed need (such as personal safety, safety of others, health and well-being)
 - State past interventions and supports used prior to any Restrictions being implemented. This includes documentation of any less intrusive methods of meeting the need that have been tried but did not work
 - Include a clear description of the Restriction that is directly proportionate to the specific assessed need (such as diagnosis, behavior, or lack of skill)

My Right Restrictions Cont'd.

Right Restrictions Must

- Include regular collection and review of data to measure the ongoing effectiveness of the Restriction
- Should be included in a skill building goals whenever it is possible to restore the right (i.e. medications, payee, phone use)
- Include established time limits for periodic reviews to determine if the Restriction is still necessary or can be terminated (documented quarterly in the members contact note/record)
Include the informed consent of the member or their legal representative
- Include an assurance that interventions and supports that make up any Restriction will cause no harm to the member, if applicable

My Right Restrictions Cont'd.

Step 1: Identify the Assessed Need

- Before implementing a Rights Restriction on the Person Centered Service Plan, a specific and individualized assessed need must be identified
- These assessed needs usually fall in to one of the following **categories** and examples:
- An example of **personal safety of the member** include: member needs supervision while in the community because they have a significant history of darting in to the street without looking for cars
 - Staff supervision is necessary to keep the member safe
- An example of **health of the member** include: member's medications are kept locked in their group home because the member cannot identify their own medications and has a history of consuming medications that are not theirs

My Right Restrictions Cont'd.

Step 1: Identify the Assessed Need Cont'd

- An example of **wellbeing of the member** may include: member has a Protective Payee for their Social Security funds
 - Member is unable to manage their money, including paying bills
 - Member cannot count or identify money
- An example of the **health, safety and/or wellbeing of others** may include: member's knives and other sharps are kept in a lock drawer in the kitchen
 - Member has threatened staff and housemates with knives and scissors in the past when upset

My Right Restrictions Cont'd.

Step 2: State Past Interventions

- List the past interventions and supports used prior to any Restrictions being implemented
- This includes documentation of any less intrusive/less restrictive methods of meeting the need that have been tried but did not work

My Right Restrictions Cont'd.

Step 3: Clearly Describe the Restriction

- Include a clear description of the Restriction that is directly proportionate to the specific assessed need (such as diagnosis, behavior, or lack of skill)
- Describe: Who, What, When, Where?
 - Example: Instead of writing the Rights Restriction as: “member needs supervision”, specify: “I require supervision from XYZ Agency SCL staff or from my legal guardian at all times while in the community because I am unable to track my location, read signs/directions, or ask for help from others.”

My Right Restrictions Cont'd.

Step 4: Collect the Data & Review

- Include regular collection and review of data to measure the ongoing effectiveness of the Restriction
- Include established time limits for periodic reviews to determine if the Restriction is still necessary or can be terminated
- Note that Rights Restrictions can be the catalyst for developing a member's goal
 - For example: If a member's assessed need is that they cannot administer their own medications and a Rights Restriction is implemented, it may be appropriate to develop a goal that will help the member develop the skills needed in order to take their medications more independently

My Right Restrictions Cont'd.

Step 5: Informed Consent

- Informed consent is the act of getting permission from the member and/or their legal representative to implement a Rights Restriction, while addressing possible consequences, including discussion of risks and benefits
- Rights Restrictions do not reflect the opinion of one individual/one agency, they are carefully developed by the Interdisciplinary Team
- The member and guardian/legal representative should always be involved in the implementation and discussion of Rights Restrictions
- The Care Coordinator must fully inform the member and their legal representative of the assessed need for the Restriction and how it will be implemented

My Right Restrictions Cont'd.

Step 6: Do No Harm

- The Care Coordinator shall ensure that interventions and supports that make up any Rights Restriction will cause no harm to the member
- Never compromise a member's dignity and respect
- Never utilize Rights Restrictions as a form of punishment
- Rights Restrictions inherently restrict a member's freedom and/or decision making, but measure should still be taken to make them the least restrictive as possible
- Unnecessarily strict Restrictions can diminish a member's independence and have a negative consequence

My Right Restrictions Cont'd.

What a Rights Restriction Should Not Be

- **Restrictions should never be put in place just because they are convenient for the provider or guardian**
 - *Example: Peter is unable to participate in art activities while at day habilitation because his guardian doesn't like to clean up paint and glitter off his clothes when he gets home*
- **Restrictions should never be implemented without consent of the member and his/her guardian (when applicable)**
 - *Example: Shady Services decides Paul cannot use his cell phone after 9pm because they believe he is staying up too late talking to friends. Shady Services takes away Paul's phone every evening at 8:45pm while he's in the shower*
 - *Paul is his own guardian and has not consented to this*

My Right Restrictions Cont'd.

What a Rights Restriction Should Not Be Cont'd

- **Restrictions ideally should not be for all members living in a setting, regardless of their individualized needs and abilities**
 - *Example: Mary's housemates cannot have alone time at home or in the community because of their need*
 - *Therefore, Mary's staff require that she also have 24 hour supervision at home and in the community*

My Right Restrictions Cont'd.

Final Note on Rights Restrictions

- Often times, we think we know what is best for the member, or believe the member will make a “bad” choice if given the option
- Care Coordinators must remember that all members, including those receiving waiver services, have the right to make choices, even when those choices result in poor outcomes
- People learn by making mistakes
- It essential that the member’s Care Coordinator advocate for member’s ability to make their own choices whenever it does not jeopardize their health and safety, or the health and safety of others
- A guardian may be granted the following powers which may only be exercised upon court approval:
 - Denying all communication, visitation, or interaction by a protected person with a person with whom the protected person has expressed a desire to communicate, visit, or interact or with a person who seeks to communicate, visit, or interact with the protected person. A court shall approve the denial of all communication, visitation, or interaction with another person only upon a showing of good cause by the guardian

My Right Restrictions Examples

Restriction	Reason for restriction	Past Interventions Tried	Plan to Restore Right that has been Restricted
I have a Representative Payee to help manage my finances	I don't feel that I am able to manage my money independently. I forget to pay my bills. Social Security requires I have a Representative Pay for my Social Security money.	I have tried to learn to balance my checkbook in the past and keep a calendar to remember to pay my bills on time. I was not successful and got evicted in 1998 due to forgetting to pay my rent.	I want to continue to have a Representative Payee. I have chosen Goodwill to be my payee. I meet with them weekly to discuss my finances. I understand this restriction will be reviewed quarterly. My guardian and I are in agreement with this restriction.
I have a Legal Guardian to help me make big decisions and protect my interests	I feel that I need help making decisions. I don't always understand things I read and get anxious when I have to make big choices. My parents, John and Sue Smith, were appointed my legal guardians when I turned 18.	My parents became my Legal Guardians when I was 18. I feel that, due to my disability, I will always need help making big decisions.	I want to continue to have a Legal Guardian. I am happy with my parents being my guardian and there are no plans for this to change in the immediate future. My sister, Sarah Smith-Doe is my Stand-By Guardian, in the event something happens to both of my parents. I understand this restriction will be reviewed quarterly. I am in agreement with this restriction.

Section 8

My Education & Employment

My Education and Employment

- My Education Level - Select appropriate choice from drop down and provide any comments
- I am currently employed – select yes or no
 - If yes, answer question a, identify who current employer is, when they started, days they work and # of hours
 - If no, answer question b, I have the following plans (include barriers or resources needed)
- I am currently volunteering – select yes or no
 - If yes, answer question a, where volunteer at, when started, days and hours worked
 - If no, answer question b, I have the following plans to volunteer (include barriers or resources needed).

My Education and Employment Cont'd

- I am currently working with Iowa Vocational Rehabilitation Services – Select yes or no
 - If yes, answer following question, IVRS counselor name, contact information and when they began working with IVRS
- I am receiving prevocational or supported employment service – select yes or no
 - If yes, answer following question, I work in the following setting
- I earn a subminimum wage – select yes or no
 - If yes, I was provided with counseling, information, and referral on date, by and what was provided
 - If no, I was not provided with counseling, information, and referral and reason

My Education and Employment Cont'd

- I am receiving small group employment - select yes or no
 - If yes, answer following question, I work with # of people and # of hours
- I am receiving individual supported employment – select yes or no
 - If yes, answer following question, I work # of hours and have on-site staff support # of hours
- I am receiving long term job coaching - select yes or no
 - If yes, answer following question, I work # of hours and have on-site staff support # of hour month

Section 9

Where I Live

Where I Live

- I live in an integrated setting of my choosing - Choose yes or no
 - Integrated setting means a setting that enables the member to interact with non-disabled persons to the fullest extent possible. The key word in this question is “choosing”.
 - Is the member living where they want to live?
 - If the member is under the age of 18, is the member living where the parent/guardian want them to live?
 - If the member has a legal guardian, has the guardian chosen the integrated setting of their choice on the member’s behalf?
- If no, my integration plan is - Fill out appropriate response
- I live – check all the boxes that are applicable
- I choose the setting in which I live now – choose yes or no and explain no

Where I Live Cont'd

- I selected the setting where I live among available alternatives – choose yes or no, explain no
 - What alternative settings were discussed - List any discussion on alternative settings or state none
- I had setting options to choose from. For example, I had the choice to live in a non-disability specific setting or to have a private unit in a residential setting – choose yes, no or NA and explain no
- The setting where I live encourages my own resourcefulness, independence, and freedom in making life choices, including but not limited to daily activities, physical environment, and with whom I choose to interact – choose yes or no and explain no
- I had a choice regarding services and supports and who provides them – choose yes or no and explain no

Where I Live Cont'd

- I had a choice regarding services and supports and who provides them – choose yes or no and explain no
- The setting where I live supports full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS - choose yes or no and explain no
- The setting where I live ensures the right to privacy, dignity and respect, and freedom from coercion and restraint – choose yes or no and explain no

Where I Live Cont'd

- I am receiving home-based habilitation services –
 - choose yes or no
- If you select yes, the next 3 questions MUST be answered
 - # of waiver member living in the home
 - # of hours of supervision member receives each day
 - Type of living environment

Where I Live Cont'd

- For members that live in the following settings:
 - E - In a setting that is a licensed facility (e.g. residential care, assisted living, other)
 - F - In a setting where two or more people receiving Medicaid funded services live together to receive waiver/habilitation services
 - G - In a setting where multiple HCBS/habilitation living units are co-located in close proximity to each other within the community
 - H - In a setting that is owned or operated by the provider of service
- The following questions need to be answered:
 - The living unit entrance doors and my bedroom door are lockable by me – choose yes or no and provide any comments
 - Staff have access to keys to my living unit – choose yes or no and provide any comments
 - I have the freedom to furnish and decorate my sleeping or living unit – choose yes or no and if no explain
 - I am able to have visitors of my choosing at any time – choose yes or no,

if no explain

Section 10

Acknowledgements

Acknowledgements

- Read the acknowledgements to the member/guardian and have them initial next to each one.
- I gave input into my assessment, right restrictions, goals and additional information included in this service plan
- I gave consent to the right restrictions that have been identified in my service plan. If I wish to change them, I can request a team meeting to review and change them. My care coordinator will review these with me at least quarterly and document my understanding of them.
- I was given a choice of providers and selected the providers I want to deliver my services.
- I am in agreement with my service plan and I know who to work with on my goals.
- I understand the information in this service plan and have had a chance to ask questions and received clarification.

Acknowledgements Cont'd

- I understand that I can request to have changes to the service plan at any time and that I contact my Care Coordinator about making changes.
- My Care Coordinator has explained to me how to make a report if I suspect I am being abused, neglected, and/or exploited.
- I understand that my Care Coordinator is responsible for monitoring my service plan.
- I understand that my Care Coordinator will meet with me face-to-face at least every 3 months or sooner, if needed. Every month there is not a face-to-face visit, my Care Coordinator will call me or my guardian, if I choose.
- I understand that my Care Coordinator will contact my providers ongoing, to assess progress with goals, to evaluate changes in need and to make necessary adjustments to the service plan.
- I understand that I have the right to appeal and that there is a grievances process. I have the right to appeal any reduction, termination or denial of services. I will receive a written letter with my appeal rights.

Acknowledgements Cont'd

- My care coordinator will contact me on or before (date) by (method).
- My care coordinator will contact (provider name) on or before (date) by (method)

Signature Page

- Each person at the IDT meeting should sign, date and state their role. At the minimum, it should include the Member and Care Coordinator.
- Care Coordinator MUST indicate the following on the signature
 - Date copy of PCSP was provide to member & team members
 - Method the PCSP was provided to the Member & team members

The people who have signed below understand and agree to participate in implementing my plan.

Signature	Print Name	Date	Role	Date a copy of this service plan was sent/ given & Method (e.g. mail, email, etc.)
			Member	
			Care Coordinator	N/A

Resources

- CMH Waiver Rates -
<https://dhs.iowa.gov/sites/default/files/Comm512.pdf?091720201708>

Q & A



Thank you!